Report

of the

Examination of

Physicians Plus Insurance Corporation

Madison, Wisconsin

As of December 31, 2002

**TABLE OF CONTENTS**

**Page**

**State of Wisconsin** / OFFICE OF THE COMMISSIONER OF INSURANCE

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***Jorge Gomez,*** *Commissioner*

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December 17, 2003

Honorable Jorge Gomez
Commissioner of Insurance
Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

PHYSICIANS PLUS INSURANCE CORPORATION
MADISON, WI

and this report is respectfully submitted.

## I. INTRODUCTION

The previous examination of Physicians Plus Insurance Corporation (company or PPIC) was conducted in 2000, as of December 31, 1999. The current examination covered the intervening period ending December 31, 2002, and included a review of such 2003 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the company's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the Company
Reinsurance
Financial Statements
Accounts and Records
Data Processing

Emphasis was placed on the audit of those areas of the company's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the company to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results " contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comments on the remaining areas of the company's operations are contained in the examination work papers.

The company is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

## II. HISTORY AND PLAN OF OPERATION

Physicians Plus Insurance Corporation is a for-profit network model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as "a health care plan offered by an organization established under ch.185, 611, 613, or 614, Wis. Stat., or issued a certificate of authority under ch. 618, Wis. Stat., that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the network model, the company provides care through contracts with two or more clinics. HMOs compete with traditional fee-for-service health care delivery.

PPIC was incorporated August 6, 1986, and commenced business October 3, 1986. PPIC is owned two-thirds (2/3) by Meriter Health Services, Inc. (MHS), and one-third (1/3) by Physicians Plus Investment Group (PPIG). Prior to December 15, 2000, PPIC was owned one-third each by Meriter Hospital, Inc. (Meriter), Wausau Service Corporation (Wausau), and Physicians Plus Investment Group (PPIG).

The company contracts with approximately 500 primary care physicians and 750 specialists. PPIC requires its enrollees to choose a primary care physician.

Under PPIC's standard provider agreement, a provider agrees to provide medical services, covered under a member's benefit contract, in accordance with the standard of practice of the provider's community. The provider agrees to establish effective procedures to provide for the availability and accessibility of medically necessary services 24 hours a day, seven days a week. The provider also agrees to not refer a member to any healthcare provider outside the participating network, without obtaining prior authorization from PPIC, except in the event of a medical emergency. The provider contract includes insolvency and hold-harmless clauses for the protection of policyholders. Generally, contracts are for a one-year term, automatically renewing for successive calendar years thereafter. An agreement may be terminated by either party upon 90 to 180 days' written notice to the other party. Providers are generally compensated on a

capitation or discounted fee-for-service basis. The contracts include a provision for withholding fees by PPIC if a provider defaulted by continued overutilization of health facilities/services after notice to desist.

The company has entered into provider agreements with the University of Wisconsin Medical Foundation (UWMF) and Meriter Hospital (Meriter). The contracts define services to be provided by UWMF and Meriter in terms of "risk pools." The risk pools are defined as follows:

(1) members with a Dane county UWMF primary care provider (PCP)
(2) members with a non-Dane county PCP or a Dane county non-UWMF PCP

Meriter and UWMF each receive a percentage of premium capitation as compensation for the medical services provided to members in Category (1), above. In addition, the Meriter contract contains a provision for capitation as compensation for the medical services that it provides to members in Category (2), above. Under the contract, Meriter is entitled to receive any reinsurance recoveries received by PPIC relevant to services that are the responsibility of Meriter. PPIC is responsible for the administration and payment of claims. PPIC delegates this task, through a contractual arrangement, to Perot Systems. The current contract was signed on October 1, 2000, and is effective through September 30, 2010.

The majority of PPIC's providers are included under contracts with UWMF for the south central service area. Beyond this arrangement, the next five largest entities contracting with PPIC are as follows:

Community Physicians Network
The Monroe Clinic
HCMS-Ft. Atkinson
Ft. Atkinson Medical Center
Internal Medicine and Pediatrics (Ft. Atkinson)

PPIC contracts with 21 hospitals to provide inpatient services. Hospitals are reimbursed on a Diagnostic Related Groups (DRG) or discounted fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders. Contract terms vary based on the specific hospital. In the south central Wisconsin service area, PPIC contracts with the following hospitals:

Beaver Dam Community Hospital, Beaver Dam
Boscobel Area Health Care, Boscobel
Columbus Community Hospital, Columbus
Divine Savior Hospital, Portage
Fort Atkinson Memorial Health Services, Fort Atkinson
Hess Memorial Hospital, Mauston
Upland Hills Health System, Dodgeville
Memorial Hospital of LaFayette County, Darlington
Memorial Community Hospital, Edgerton
Meriter Hospital, Madison
Oconomowoc Memorial Hospital
Reedsburg Area Medical Center, Reedsburg
Richland Hospital, Richland Center
Sauk Prairie Memorial Hospital, Prairie du Sac
St. Clare Hospital, Baraboo
St. Josephs Community Hospital-Hillsboro
Stoughton Hospital, Stoughton
The Monroe Clinic, Monroe
University of Wisconsin Hospital and Clinics
Watertown Memorial Hospital, Watertown
Waupun Memorial Hospital, Waupun

During 2002, PPIC arranged to have certain benefits managed by other entities: Chirotech America, Inc. (CTA), for chiropractic care services and Madison Family Dental Associates (MFDA) for dental services. Under the contracts, CTA and MFDA receive a monthly capitation fee as compensation for services provided.

As of October 2003, PPIC's service area was comprised of the following counties:

Columbia, Dane, Dodge, Green, Iowa, Jefferson, Richland, Rock, and Sauk.

PPIC offers comprehensive health care coverage which may be changed by riders to include deductibles and copayments. The following basic health care coverages are provided:

- Physician services
- Inpatient services
- Outpatient services
- Mental health, drug, and alcohol abuse services
- Ambulance services
- Special dental procedures (oral surgery)
- Prosthetic devices and durable medical equipment
- Well-child services
- Home health care
- Preventive health services
- Family planning
- Hearing exams and hearing aids
- Diabetes treatment
- Prescription drugs--one copay for generic; two copay for brand-name
- Routine eye examinations
- Skilled nursing home service
- Cardiac rehabilitation, physical, speech, and/or occupational therapy
- Health education
- Certain transplants
- Chiropractic services

Mental health (MH) and Alcohol and Other Drug Abuse (AODA) coverage is limited to a maximum benefit per calendar year of $6,300. The following limits also apply:

MH and AODA—

20 visits per year for outpatient
18 days per year for transitional
12 days per year for inpatient

AODA days and visits count toward the MH maximum totals. Emergency services have a copayment which is waived upon admission into an inpatient facility. Skilled nursing care is limited to 100 days and home health care to 100 visits. Plan coverage is contingent on nonemergency services being provided by participating physicians and hospitals or on the referral of participating physicians. PPIC also has various copayment plans in which specified preventive and outpatient services have a copayment ranging from $10 to $35. Some plans have a coinsurance amount ranging from 10% - 30%. There is a maximum out-of-pocket amount ranging from $250 - $2,000 for individuals and $500 - $5,000 for families. Members are required to choose a primary care physician from the listing of participating physicians available.

The company also has point-of-service products offered in conjunction with an affiliate, Meriter Health Insurance Company, that provide comprehensive benefits similar to those listed above when participating providers are used. The enrollee may elect, at the time of service to use providers that are not part of the HMO network for higher deductibles and coinsurance levels. Certain preventive services are not covered when out-of-network providers are used. Out-of-Network services that still require precertification include:

| Precertification Requirement | Coverage Without Precertification |
|---|---|
| Outpatient or day surgical procedures and all related facility and professional charges | 50% of eligible expenses up to $500 |
| Inpatient hospital, inpatient hospice Care and all health services provided during confinement (facility and professional charges) | 50% of eligible expenses up to $500 |
| Home Care | 50% of eligible expenses |
| Prosthetics | No benefit |
| Durable medical equipment which exceeds $500 in cost. | No benefit |
| All durable medical equipment rentals | No benefit |

Reimbursement for these services are reduced to either 50% of the covered amount or not covered, up to a maximum of $500 per occurrence, as a penalty for failing to obtain precertification.

PPIC currently markets to both groups and individuals. PPIC uses internal sales staff, as well as outside agencies. Nongroup and groups in the range of 2-100 employees are sold primarily through agents. Agents are paid commissions on new and renewal business, according to the following schedule:

| Number in Group | New Group Commission | Renewal Commission |
|---|---|---|
| Individual | $20.05 | $20.05 |
| 2-9 | 22.28 | 15.05 |
| 10-49 | 27.30 | 20.05 |
| 50-99 | 11.70 | 11.14 |
| 100+ | 7.24 | 6.68 |

PPIC uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, and coverage characteristics for new groups. For renewals, experience is reviewed for large groups with "ongoing group conditions" being considered for small groups (less than 50 individuals). The base rate is adjusted annually for trending factors. A large group manual rate may be adjusted by the Underwriting Department based on other risk evaluation factors (for example, claims experience and health status).

## III. MANAGEMENT AND CONTROL

### Board of Directors

The board of directors consists of seven members. Meriter Health Services, Inc., nominates four directors, Physicians Plus Investment Group (PPIG) nominates two directors and MHS and PPIG jointly nominate one director. Directors are elected annually at the shareholders meetings. Officers are appointed by the board of directors. Members of the company's board of directors may also be members of other boards of directors in the holding company group. The board members currently receive $150/monthly meeting attended for serving on the board. The board chair receives $2,000 per month. Committee members also receive $150 per meeting attended, with committee chairs generally receiving $300 per month.

Currently, the board of directors consists of the following persons:

| Name and Residence | Principal Occupation | Term Expires |
|---|---|---|
| Ashley Anderson, M.D.<br>Madison, WI | Physician | * |
| Thomas Fuss<br>Cross Plains, WI | VP & CFO Meriter Health Services, Inc. | * |
| John Pollack<br>Madison, WI | President & CEO General Casualty Companies | * |
| Terri Potter<br>Madison, WI | President & CEO, Meriter Health Services, Inc. & Meriter Hospital | * |
| Geoffrey Priest, M.D.<br>Madison, WI | Senior VP Medical Affairs, Meriter Hospital | * |
| Larry Rothstein, M.D.<br>Verona, WI | Anesthesiologist, Madison Anethesia Consultants | * |
| Paul Zucarelli<br>Marana, AZ | Principal, Gordon, Zucarelli Handley Business Services, Inc. | * |

* Directors hold office until a successor has been elected, or until death, resignation, or removal.

**Officers of the Company**

The officers appointed by the board of directors and serving at the time of this examination are as follows:

| Name | Office | 2002 Salary |
|---|---|---|
| Ashley Anderson, M.D. | Chairman of the Board | * |
| Terri Potter | Vice Chairman of the Board | * |
| Martin Preizler | President & CEO | $315,848 |
| William Jollie | Executive Vice President & Chief Administrative Officer | 212,844 |
| John Martin, Ph.D | Vice President of Organizational Effectiveness | 117,261 |
| Kathryne McGowan | Vice President of Marketing and Sales | ** |
| Michael Mohoney | Vice President, CFO and Treasurer | 186,362 |
| Ronald Parton, M.D. | Vice President and Chief Medical Officer | 271,092 |
| Jacqueline Kettner | Secretary of the Board | *** |
| Carin van Doremalen | Assistant Secretary Board | *** |

*No additional salary is paid to these individuals. Compensation consists of the amounts paid to board members as noted in the preceding section.

**Was not elected to this position until September of 2002

***Compensation was not on Executive Compensation Report.

**Committees of the Board**

The company's bylaws allow for the formation of certain committees by the board of directors. The committees at the time of the examination are listed below:

**Executive Committee**

Ashley Anderson, MD, Chair
Terri Potter
Tom Fuss
Larry Rothstein, MD **

**Finance & Audit Committee**
Tom Fuss, Chair
Linda Hoff
Fred McGee
Kok Peng Yu, MD
David Ringdah, MD

**Credentialing Committee**

Gary Allen, MD, Chair
Timothy Barlow, MD
William Hisgen, MD
Terri Michel, CNP
Ron Parton, MD
Carl Weston, MD
Sarah Linda**
David Gebauer**

**Quality & Utilization Management Committee**
Ashley Anderson, MD, Chair
Gail Allen, MD
Timothy Bartholow, MD
Geoff Priest, MD
Lisa Brinn, MD
Nadine French, MD
William Higsen, MD
Ron Parton, MD
John Martin
Kristen Albers
Doug Kramer, MD
David Gebauer
Martin Preizler
Lori Hauschild
Kate Nisbet
Sue Pelatzke

** Denotes non voting member

Certain activities of the HMO have been delegated to outside organizations under management services or administrative agreements. The HMO has an administrative services agreement with Perot Systems Corporation of Dallas, Texas. The contract provides for the following services:

- Data systems
- Enrollment benefit plans and issuance
- Premium billing and collections
- Claims administration

Perot receive a fixed per-member-per-month fee as compensation for its services.

Since 1991, PPIC has had an agreement with Argus Health Systems, Inc., for the administration of drug claims. Services provided in the Argus contract include:

- Receipt, processing, and adjudication of all drug claims
- Preparation of checks
- Submission of checks for verification
- Issuance of checks upon approval
- Rebate preparation and administration

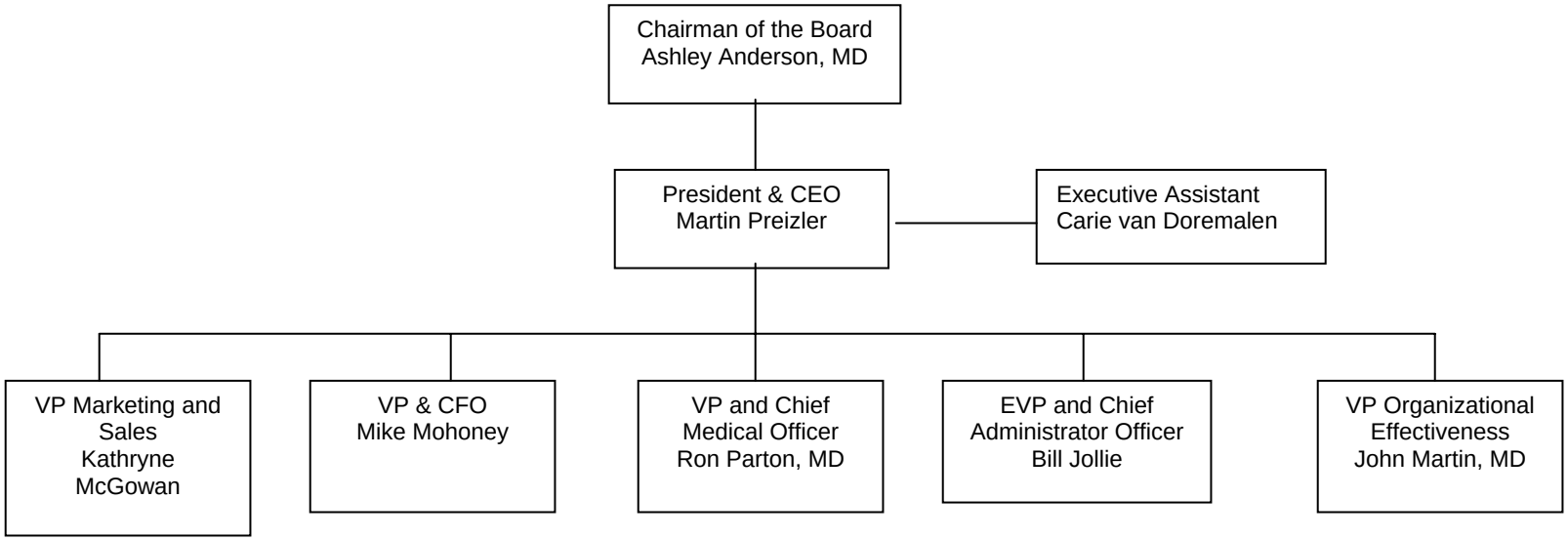
Compensation to Argus consists of a specified amount per claim processed, varying by the volume of claims per month. The fee schedule outlines additional charges which are incurred for other specified services. The current agreement, effective January 1, 2000, has a three-year term, and is automatically renewable for successive one-year terms unless either party gives the other written notice of nonrenewal at least 90 days prior to the end of the then-current term.

In 1995, PPIC entered into an agreement with SVA Diversified Services, Inc. Under this agreement SVA provides claims administration services for dental services rendered by Madison Family Dental Associates providers. SVA is compensated on a capitated basis.

Effective December 1, 2000, PPIC entered into an agreement with ADVANA, Inc. (ADVANA), formerly known as HealthCare Cost Recovery, Inc. Under this agreement, ADVANA performs certain identification, notification, negotiation, claims savings, and recovery services in connection with the claims paid or administered on behalf of PPIC which may be eligible for reduction in payment from other primary insurance sources, or for subrogation/reimbursement under personal injury or other third party laws. ADVANA receives 25% of all monies recovered on behalf of the company.

PPIC has a staff of approximately 135 individuals, organized into departments as indicated on the organizational chart on the following page.

**Physicians Plus Insurance Corporation**
**Organizational Chart**
**Executive - Administrative**



**Financial Requirements**

The financial requirements for a company under s. Ins 9.04, Wis. Adm. Code, are as follows:

| | | Amount Required |
|---|---|---|
| 1. | Minimum capital or permanent surplus | Either:<br>$750,000, if organized on or after July 1, 1989<br>or<br>$200,000, if organized prior to July 1, 1989 |
| 2. | Compulsory surplus | The greater of $750,000 or:<br><br>If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months;<br><br>If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months |
| 3. | Security surplus | The greater of:<br>140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million<br>or<br>110% of compulsory surplus |
| 4. | Operating funds | Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus |

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;

2. One-third of 1% of premium written in this state in the preceding calendar year.

The company has satisfied this requirement for 2002 with a deposit of $2,400,000 with the State Treasurer.

**Insolvency Protection for Policyholders**

Under s. Ins 9.04 (6), Wis. Adm. Code, companies are required to provide continuation of coverage for its enrollees. These requirements are the following:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

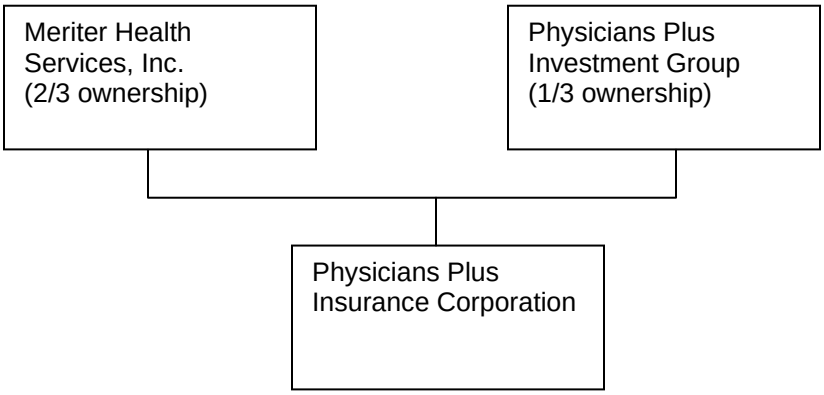
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The company has met this requirement through its reinsurance contract, as discussed in the Reinsurance section of this report.

## IV. AFFILIATED COMPANIES

The company is a member of a holding company system. Its ultimate parent is Meriter Health Services, Inc. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the company follows the organizational chart.

**Holding Company Chart**
**As of December 31, 2002**




**Physicians Plus Investment Group**

Physicians Plus Investment Group (PPIG) is a partnership, established on September 1, 1986, to purchase and own PPIC common stock. The majority of PPIG members are practicing physicians of UWMF. Management and conduct of partnership business is vested in an executive committee.

**Meriter Health Services, Inc.**

Meriter Health Services, Inc., is a nonstock, nonprofit organization that services as a parent corporation for the corporate group and supports its subsidiary corporations. MHS's subsidiaries provide health care related services to residents of Dane County and southern Wisconsin. As of December 31, 2002, MHS's audited financial statements reported assets of $369 million, liabilities of $230 million, and surplus of $139 million. Operations for 2002 produced a decrease in unrestricted net assets of $18 million.

## V. REINSURANCE AND CORPORATE INSURANCE

The company has reinsurance coverage under the contract outlined below:

| | |
|---|---|
| Reinsurer: | Reliastar Life Insurance Company |
| Type: | Specific Excess of Loss Reinsurance |
| Effective date: | January 1, 2003 |
| Retention: | $150,000 of eligible inpatient hospital services |
| Coverage: | Coinsurance listed is in excess of the annual deductible.<br><br>90%, except for non-approved transplants<br><br>60%, for non-approved transplants<br><br>Eligible inpatient hospital services are limited to the lesser of: $4,000 average per day, 100% of billed charges, the amount paid by the plan, or the contracted amount.<br><br>Eligible inpatient hospital services for Meriter Hospital are limited for each member to: $1,525 average per day for medical and surgical confinements, $2,336 average per day for ICU confinements, and $2,426 average per day for NICU confinements.<br><br>The maximum reinsurance coverage payable during any agreement year for eligible services for each member is $2,000,000. The maximum lifetime reinsurance coverage for all agreement years for each member is $2,000,000. |
| Premium: | $0.90 per member per month for commercial members<br>$0.90 per member per month for point-of-service members |
| Termination: | The agreement is for a one-year term and may be renegotiated within 60 days prior to the end of the agreement period. |

The reinsurance policy has an endorsement containing the following insolvency provisions:

1. Reliastar will continue plan benefits for members who are confined in an acute-care hospital on the date of insolvency until their discharge.

2. Reliastar will continue plan benefits for any member-insured plan until the end of the contract period for which premiums have been paid to plan by that member or on his behalf.

3. Reliastar will make available to all members for a period of days, without evidence of insurability, a replacement coverage of the same benefit schedule and rates as then being offered by Reliastar to other prospective insureds within the state.

There is a limit on the insolvency coverage of $20 million dollars.

In addition, the company is provided with corporate insurance coverage under the contracts listed below:

| Type of Coverage | Policy Limits |
|---|---|
| Directors' and officers' liability | $25,000,000 |
| Professional liability | |
| Managed Care Errors and Omissions Liability | 10,000,000 |
| Workers Compensation | |
| Bodily injury by accident | 500,000 each accident |
| Bodily injury by disease | 500,000 |
| Commercial Crime | |
| Employee Dishonesty | 5,000,000 |
| Computer Fraud | 5,000,000 |
| Loss Inside / Outside | 250,000 |
| Aviation Non-ownership Liability | 10,000,000 |
| Commercial Auto | 1,000,000 |
| Umbrella Liability | 85,000,000 |
| Fiduciary | 10,000,000 |

The above coverages were obtained through a number of insurer licensed with the state of Wisconsin and surplus lines insures listed on the commissioner's current list of approved surplus lines insurers.

## VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported in the December 31, 2002, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the company for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

**Physicians Plus Insurance Corporation**
**Assets**
**As of December 31, 2002**

| | Assets | Nonadmitted Assets | Net Admitted Assets |
|---|---|---|---|
| Bonds | $19,098,860 | $ | $19,098,860 |
| Stocks: | | | |
| Preferred stocks | 1,936,500 | | 1,936,500 |
| Common stocks | 1,920,521 | | 1,920,521 |
| Cash and short-term investments | 6,511,409 | | 6,511,409 |
| Other long-term invested assets | 76,372 | | 76,372 |
| Accident and health premiums due and unpaid | 868,759 | (113,227) | 981,986 |
| Health care receivables | 7,922,859 | 393,751 | 7,529,108 |
| Amounts recoverable from reinsurers | 1,169,607 | | 1,169,607 |
| Investment income due and accrued | 311,906 | | 311,906 |
| Amounts due from parent, subsidiaries and affiliates | 3,995,295 | | 3,995,295 |
| Furniture and equipment | 674,593 | 674,593 | 0 |
| Federal and foreign income tax recoverable and interest thereon | 1,924,362 | | 1,924,362 |
| Electronic data processing equipment and software | 534,477 | | 534,477 |
| Other nonadmitted assets | 249,736 | 249,736 | 0 |
| Aggregate write-ins for other than invested assets | 1,624,599 | 1,226,284 | 398,315 |
| Total assets | $48,819,855 | $2,431,137 | $46,388,718 |

**Physicians Plus Insurance Corporation**
**Liabilities and Net Worth**
**As of December 31, 2002**

| | | |
|---|---|---|
| Claims unpaid | | $ 9,131,388 |
| Accrued medical incentive pool and bonus payments | | 160,040 |
| Unpaid claims adjustment expenses | | 208,917 |
| Premiums received in advance | | 6,266,514 |
| General expenses due or accrued | | 4,356,254 |
| Federal and foreign income tax payable and interest thereon | | 212,965 |
| Total liabilities | | 20,336,078 |
| Common capital stock | $2,145,000 | |
| Preferred capital stock | 3,462,000 | |
| Gross paid in and contributed surplus | 10,492,743 | |
| Surplus notes | 3,928,571 | |
| Aggregate write-ins for other than special surplus funds | 981,191 | |
| Unassigned funds (surplus) | 5,043,135 | |
| Total capital and surplus | | 26,052,640 |
| Total liabilities, capital and surplus | | $46,388,718 |

**Physicians Plus Insurance Corporation**
**Statement of Revenue and Expenses**
**For the Year 2002**

| | | |
|---|---|---|
| Net premium income | | $233,081,075 |
| Aggregate write-ins for other health care related revenues | | 621,600 |
| Total revenues | | 233,702,675 |
| Medical and Hospital: | | |
| Hospital/medical benefits | $140,549,174 | |
| Other professional services | 11,495,298 | |
| Emergency room and out-of-area | 1,226,165 | |
| Prescription drugs | 37,695,273 | |
| Aggregate write-ins for other medical and hospital | 1,219,115 | |
| Incentive pool and withhold adjustments | 160,040 | |
| Subtotal | 192,345,065 | |
| Less | | |
| Net reinsurance recoveries | 472,219 | |
| Total medical and hospital | 191,872,846 | |
| Claims adjustment expenses | 2,489,896 | |
| General administrative expenses | 24,103,226 | |
| Total underwriting deductions | | 218,465,968 |
| Net underwriting gain or (loss) | | 15,236,707 |
| Net investment income earned | 957,417 | |
| Net realized capital gains or (losses) | (58,480) | |
| Net investment gains or (losses) | | 898,937 |
| Aggregate write-ins for other income or expenses | | (230,025) |
| Net income or (loss) before federal income taxes | | 15,905,619 |
| Federal and foreign income taxes incurred | | 6,732,357 |
| Net income (loss) | | $ 9,173,262 |

**Physicians Plus Insurance Corporation**
**Capital and Surplus Account**
**As of December 31, 2002**

| | | |
|---|---|---|
| Capital and surplus prior reporting year | | $16,158,860 |
| Net income or (loss) | $9,173,262 | |
| Net unrealized capital gains and losses | 561,980 | |
| Change in nonadmitted assets | 3,729,967 | |
| Change in surplus notes | (3,571,429) | |
| Net change in capital and surplus | | 9,893,780 |
| Capital and surplus end of reporting year | | $26,052,640 |

**Physicians Plus Insurance Corporation**
**Statement of Cash Flows (Direct Method)**
**As of December 31, 2002**

| | | | |
|---|---|---|---|
| **Cash from Operations** | | | |
| Premiums and revenues collected net of reinsurance | | | $233,224,765 |
| Claims and claims adjustment expenses | | | 195,319,601 |
| General administrative expenses paid | | | 22,651,966 |
| Other underwriting income (expenses) | | | 621,600 |
| Cash from underwriting | | | 15,874,798 |
| Net investment income | | | 1,068,879 |
| Other income (expenses) | | | (230,025) |
| Federal and foreign income taxes (paid) recovered | | | (6,519,392) |
| Net cash from operations | | | 10,194,260 |
| **Cash from Investments** | | | |
| Proceeds from investments sold, matured or repaid: | | | |
| Bonds | $2,395,000 | | |
| Stocks | 1,184,225 | | |
| Total investment proceeds | | $ 3,579,225 | |
| Cost of investments acquired (long-term only): | | | |
| Bonds | 9,557,060 | | |
| Stocks | 2,530,705 | | |
| Total investments acquired | | 12,087,765 | |
| Net cash from investments | | | (8,508,540) |
| **Cash from Financing and Miscellaneous Sources** | | | |
| Cash provided: | | | |
| Surplus notes, capital and surplus paid in | (3,571,429) | | |
| Other cash provided | 2,437,516 | | |
| Total | | (1,133,913) | |
| Cash applied: | | | |
| Net transfers to affiliates | 2,270,395 | | |
| Other applications | 5,186,369 | | |
| Total | | 7,456,764 | |
| Net cash from financing and miscellaneous sources | | | (8,590,677) |
| Net change in cash and short-term investments | | | (6,904,957) |
| Cash and short-term investments: | | | |
| Beginning of year | | | 13,416,366 |
| End of year | | | $ 6,511,409 |

**Growth of Physicians Plus Insurance Corporation**

| Year | Assets | Liabilities | Capital and Surplus | Premium Earned | Medical Expenses Incurred | Net Income |
|---|---|---|---|---|---|---|
| 2002 | $46,388,718 | $20,336,078 | $26,052,640 | $233,081,075 | $192,345,065 | $9,173,262 |
| 2001 | 39,678,441 | 23,519,581 | 16,158,860 | 217,005,879 | 188,228,911 | 6,636,317 |
| 2000 | 29,065,816 | 15,322,833 | 13,742,983 | 235,135,372 | 224,347,001 | (6,035,217) |
| 1999 | 32,791,247 | 20,925,002 | 11,866,245 | 210,460,735 | 198,157,028 | (4,038,365) |

| Year | Profit Margin | Medical Expense Ratio | Administrative Expense Ratio | Change in Enrollment |
|---|---|---|---|---|
| 2002 | 3.92% | 82.5% | 11.4% | (4.7)% |
| 2001 | 3.05 | 86.7 | 10.8 | (16.5) |
| 2000 | (2.56) | 95.4 | 9.9 | (5.2) |
| 1999 | (1.91) | 94.2 | 10.8 | 12.0 |

**Enrollment and Utilization**

| Year | Commercial Enrollment | Medicaid Enrollment | Hospital Days/1,000 | Average Length of Stay |
|---|---|---|---|---|
| 2002 | 97,519 | 0 | 222.42 | 3.8 |
| 2001 | 102,326 | 0 | 240.98 | 4.2 |
| 2000 | 120,569 | 1,923 | 200.00 | 3.7 |
| 1999 | 126,183 | 3,004 | 244.03 | 3.5 |

**Per Member Per Month Information**

| | 2002 | 2001 | Percentage Change |
|---|---|---|---|
| **Premiums:** | | | |
| Commercial | $201.09 | $174.88 | 15.0% |
| **Expenses:** | | | |
| Hospital/medical benefits | 121.26 | 112.32 | 8.0 |
| Other professional services | 9.92 | 9.18 | 8.1 |
| Emergency room and out-of-area | 1.06 | 1.00 | 6.0 |
| Prescription Drugs | 32.52 | 28.40 | 14.5 |
| Other medical and hospital | 1.05 | 0.47 | 123.4 |
| Incentive pool and withhold adjustments | 0.14 | 0.32 | (56.3) |
| Less: Net reinsurance recoveries | 0.41 | 0.29 | 41.4 |
| Total medical and hospital | 165.54 | 151.40 | 9.3 |
| Claims adjustment expenses | 2.15 | 2.15 | 0.0 |
| General administrative expenses | 20.79 | 16.80 | 23.8 |
| Total underwriting deductions | $188.48 | $170.35 | 10.6 |

The company has produced favorable financial results in 2001 and 2002 with reported net income of $6,636,317 and $9,173,262, respectively. Enrollment declined due to the company's exit from the Medicaid and southeastern Wisconsin markets which had purportedly contributed to the negative financial trends of the company in prior years.

**Reconciliation of Capital and Surplus per Examination**

The following schedule is a reconciliation of capital and surplus between that reported by the company and as determined by this examination:

| | | | |
|---|---|---|---|
| Capital and surplus December 31, 2002, per annual statement | | | $26,052,640 |
| Examination Adjustments: | **Increase** | **Decrease** | |
| Bonds | | $(1,052,344) | |
| Claims Unpaid | $791,874 | | |
| Net increase or (decrease) | $791,874 | $(1,052,344) | (260,470) |
| Capital and surplus December 31, 2002, per examination | | | $25,792,170 |

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Examination Reclassifications

| | **Debit** | **Credit** |
|---|---|---|
| Unassigned Funds | $981,191 | |
| Unrealized Gain/Loss on Investments | | $981,191 |
| Total reclassifications | $981,191 | $981,191 |

## VII. SUMMARY OF EXAMINATION RESULTS

### Compliance with Prior Examination Report Recommendations

There were four specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the company are as follows:

1. Conflict of Interest—It is again recommended that the company have its board of directors, officers, and key employees complete conflict of interest questionnaires on an annual basis.

   Action—Compliance

2. Investments—It is again recommended that the company amend its custodial agreements to include the proper indemnification clauses regarding the prompt replacement of securities.

   Action—Compliance

3. Financial Reporting— It is recommended that the company not admit receivables that are due from individual practice associations (IPA), in accordance with s. Ins 9.11, Wis. Adm. Code.

   Action—Compliance

4. EDP Environment—It is recommended that the company update its disaster recovery plan to incorporate the new processes that will exist with Perot Systems and address its own facilities issues. In addition, the plan should be reviewed, updated, and tested annually.

   Action—Partial Compliance, see comments in Summary of Current Examination Results

**Summary of Current Examination Results**

**Financial Reporting**

Examination review of Schedule Y - Part 2 noted that the schedule was not being completed in accordance with the National Association of Insurance Commissioners (NAIC) Annual Statement Instructions - Health. The instructions provide that the total for each column on the schedule should equal zero and if the company is a payor and recipient for any one column, the amounts should be netted on one line. The company is not netting the amount on the schedule and is not reconciling the columns so that each column totals zero. In addition, PPIC is not including amounts paid to Meriter as capitation payments in the Schedule. These amounts are paid pursuant to a service agreement and should be reported as such. It is recommended the company complete Schedule Y - Part 2 pursuant to the NAIC Annual Statement Instructions - Health.

The company is not completing the Underwriting and Investment Exhibit - Part 2B using actual paid data. The purpose of this exhibit is to disclose the development of the prior year's unpaid claim liability by comparing a) current period payments for claims with dates of service prior to the current period to b) the reserve established for those claims in the previous year's annual statement. The company is completing the exhibit as if it is paying claims on a 100% capitation basis, that is, the reserve development exactly matches the reserve liability. The examination determined that the company is collecting data that would enable it to properly complete the exhibit. It is recommended that the company complete the Underwriting and Investment Exhibit - Part 2B using actual paid claim data.

PPIC and MHIC are including unrealized gains/losses on investments as an aggregate write-in to capital and surplus. Pursuant to the NAIC Annual Statement Instructions - Health, unrealized gains and losses on investments are to be included in the Unassigned Funds balance. Due to the materiality of the amount, the examination reclassified $981,191 on PPIC's 2002 financial statement from a surplus write-in item to unassigned funds. This reclassification is reflected in the section of this report captioned "Reconciliation of Capital and Surplus per

Examination." It is recommended the company record unrealized gains/losses on investments in unassigned funds pursuant to the NAIC Annual Statement Instructions - Health.

**Investments**

The company responded in the negative to General Interrogatory 11 regarding whether the Board or a subordinate committee approves investment transactions. Examination review of the board and committee minutes did not indicate any review or approval of investment transactions was occurring. It was noted that the company's investment broker presents an overview of the investment portfolio at least twice per year to the Board. It appears that the company's board of directors is not exercising proper oversight over the company's investment activities. It is recommended that the Board of Directors, or a subordinate committee thereof, review and approve all investment transactions on a regular basis.

PPIC is valuing all bonds at market value. Statement of Statutory Accounting Principle (SSAP) #26, Paragraph 7 requires bonds that are designated highest-quality and high-quality (NAIC designations 1 and 2, respectively) to be reported at amortized cost; with all other bonds (NAIC designations 3 to 6) being reported at the lower of amortized cost or fair value. An adjusting entry of $1,052,344 has been made for examination purposes to write down the statement value of bonds to their amortized cost on PPIC's financial statement. This $1.1 million decrease to surplus is reflected in the section of this report captioned"Reconciliation of Capital and Surplus per Examination." It is recommended that the company value and report bonds rated as NAIC Class 1 or Class 2 at amortized cost, in accordance with SSAP #26.

PPIC's calculation of interest income due and accrued is based on the cost of the bond, not the par value. It is recommended that the company calculate and report interest income due and accrued for bonds based on the par value of the bond.

**Losses**

Examination review of the company's losses indicated that company management established a reserve at December 31, 2002, related to the anticipated redemption of dental coupons that had been provided to State of Wisconsin enrollees. The review of activity

during 2003 indicated that the reserve was overestimated by $791,874. This $791,874 increase to surplus is reflected in the section of this report captioned “Reconciliation of Capital and Surplus per Examination.”

**Provider Contracts**

The review of the company’s provider contracts disclosed one hospital contract in which the terms have not been changed to reflect the current practices of the company. In this instance the contract referenced the wrong administrator and the provision for payment was incorrect. It is recommended the company update its provider contracts to reflect actual practices and processes.

**Reinsurance**

PPIC does not maintain an aging of its reinsurance recoveries. The company provided a list of all amounts due from the reinsurer for specific claims. Examination testing included looking at the date the claim was paid and comparing it to the subsequent receipt from the reinsurer. Testing provided that in many cases the claim had been paid, however, the company did not receive the reimbursement from the reinsurer until months later because the company was not tracking the claim and therefore did not make a timely filing. It is recommended the company maintain an aging of reinsurance recoveries.

Examination review of PPIC’s Schedule S – Part 3 disclosed the company reported $421,770 in premiums ceded to Reliastar Life Insurance Company (Reliastar). Reliastar’s statement reported premiums assumed from PPIC of $815,777. The amount reported on PPIC’s statement represents only PPIC’s expense for reinsurance and does not include Meriter Hospital’s portion of the expense. The company should be reporting all amounts paid out under reinsurance contracts on Schedule S. In addition, the company reported the reinsurer as ING Re instead of Reliastar on the schedule. It is recommended the company correctly report amounts ceded under reinsurance contracts on Schedule S as well as reporting the correct reinsurer.

**Information Systems**

The company outsources a significant portion of its day to day processing operations and hosting to Perot Systems as described in the Management and Control section of this report.

The company was requested to provide a Statement on Audit Standards (SAS) 70 which would have documented the controls of the outside service center. It was indicated that a SAS 70 was not available to the company. Certain high level documents were requested to document some of the outside service center controls and processes. As a result, little reliance was placed on the controls of the service center. It is recommended that the company obtain a SAS 70 for future OCI examinations.

The prior examination report recommended that the HMO update its disaster recovery plan to incorporate the new processes that will exist with Perot Systems and address its own facilities issues. In addition, the plan should be reviewed, updated and tested annually. The current examination noted that the HMO started work on updating its disaster recovery plan in the fourth quarter 2002 and does not expect to complete the process until the fourth quarter of 2004. A review of the existing plan indicated that the company had included a fair amount of high level information, but still needed to incorporate detailed information into the plan, including manual processes. For the purposes of this examination, it has been determined that the company has partially complied with the prior recommendation. Since the plan has not been completed, evidence of whether the plan had been reviewed, updated and tested annually could not be determined. It is again recommended that the company review, update and test its disaster recovery plan annually.

**Compulsory Surplus Requirement**

As noted in the section of this report captioned "Financial Requirements," companies are required to maintain minimum compulsory surplus. The company's calculation as of December 31, 2002, as modified for examination adjustments is as follows:

| | | |
|---|---|---|
| Assets | $46,388,718 | |
| Less: | | |
| Special deposit | 2,400,000 | |
| Liabilities | 20,336,078 | |
| Examination adjustments | 260,470 | |
| Total | | $23,392,170 |
| Net premium earned | $233,081,075 | |
| Compulsory factor | 3% | |
| Compulsory surplus | | 6,992,432 |
| Compulsory Excess | | $16,399,738 |

## VIII. CONCLUSION

Physicians Plus Insurance Corporation's 2002 annual statement reported assets of $46,388,718, liabilities of $20,336,078 and surplus of $26,052,640. Net income of $9,173,262 was reported on revenues of $233,081,075.

Subsequent to the completion of fieldwork of this examination, Physicians Plus Insurance Corporation and Meriter Health Insurance Company received approval from the Office of the Commissioner of Insurance to merge Meriter Health Insurance Company into PPIC as of December 31, 2003.

The current examination resulted in one reclassification and two adjustments to surplus. The reclassification recorded unrealized gains/losses on investments from a surplus write-in item to unassigned funds. The examination decreased surplus by $1,052,344 to record bonds at that their amortized value and increased surplus by $791,874 for the overstatement of its loss reserves, for a net reduction in capital and surplus of $260,470. Eleven recommendations were made as a result of the examination and are summarized on the following page.

## IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 26 - Financial Reporting—It is recommended the company complete Schedule Y - Part 2 pursuant to the NAIC Annual Statement Instructions - Health.

2. Page 26 - Financial Reporting—It is recommended that the company complete the Underwriting and Investment Exhibit - Part 2B using actual paid claim data.

3. Page 27 - Financial Reporting—It is recommended the company record unrealized gains/losses on investments in unassigned funds pursuant to the NAIC Annual Statement Instructions - Health.

4. Page 27 - Investments—It is recommended that the Board of Directors, or a subordinate committee thereof, review and approve all investment transactions on a regular basis.

5. Page 27 - Investments—It is recommended that the company value and report bonds rated as NAIC Class 1 or Class 2 at amortized cost, in accordance with SSAP #26.

6. Page 27 - Investments—It is recommended that the company calculate and report interest income due and accrued for bonds based on the par value of the bond.

7. Page 28 - Provider Contracts—It is recommended the company update its provider contracts to reflect actual practices and processes.

8. Page 28 - Reinsurance—It is recommended the company maintain an aging of reinsurance recoveries.

9. Page 28 - Reinsurance—It is recommended the company correctly report amounts ceded under reinsurance contracts on Schedule S as well as reporting the correct reinsurer.

10. Page 29 - Information Systems—It is recommended that the company obtain a SAS 70 for future OCI examinations.

11. Page 29 - Information Systems—It is again recommended that the company review, update and test its disaster recovery plan annually.

## X. SUBSEQUENT EVENT

On December 4, 2003, Physicians Plus Insurance Corporation and Meriter Health Insurance Company received approval from the Office of the Commissioner of Insurance to merge Meriter Health Insurance Company into PPIC as of December 31, 2003.

MHIC was formed for the sole purpose of assuming and continuing to write the incidental indemnity portion of the PPIC point-of-service product and the small amount of indemnity coverage that is required by certain PPIC employers for employees who are located outside of the PPIC service area. MHIC has no employees and all operations were conducted through an administrative services agreement with PPIC. PPIC now has the resources to assume and continue to write the indemnity portion of business.

## XI. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the company is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

| Name | Title |
|---|---|
| Sarah Salmon | Insurance Financial Examiner |
| Randy Milquet | Insurance Financial Examiner-Advanced |

Respectfully submitted,

Danielle C. Rogacki
Examiner-in-Charge